No. 95-1594

Supreme Court, U.S.
FILED
NOV 29 1996
CLERK

IN THE
Supreme Court of the United States
OCTOBER TERM, 1996

BARBARA A. DEBUONO, M.D., in her capacity as New York State Commissioner of Health; KAREN SCHIMKE in her capacity as New York State Executive Deputy Commissioner of Health; DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners,

v.

NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER JAMES P. MALIA, GERALD OWENS, and PETER VICKERS,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF OF *AMICI CURIAE* HEALTHCARE ASSOCIATION OF NEW YORK STATE AND AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF PETITIONERS

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WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

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BRIEF OF *AMICI CURIAE* HEALTHCARE ASSOCIATION OF NEW YORK STATE AND AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF PETITIONERS

Pursuant to Rule 37 of the Rules of this Court, the Healthcare Association of New York State ("HANYS") and the American Hospital Association ("AHA") respectfully submit this brief, as *amici curiae*, in support of Petitioners. Letter of consent by the parties have been filed with the Clerk of the Court.

It is the position of the *amici* that the preemption provision (section 514(a)) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144(a)(1994), does not apply with respect to a health care facility assessment (N.Y. PUB. HEALTH LAW § 2807-d (McKinney Supp. 1996)) (the "HFA") applied to a hospital established and operated by a self-insured employee benefit plan, where such assessment is imposed equally upon all hospitals in the state.

INTEREST OF AMICI CURIAE

Employee benefit plans covered under ERISA, 29 U.S.C. §§ 1001-1461 (1994), provide benefits to their members in a variety of ways. With respect to health care, for example, most plans provide coverage through commercial insurers or by self-insurance. The Respondent NYSA-ILA Medical and Clinical Services Fund (the "Fund") has adopted an approach that has become increasingly more common; it has established and operates medical clinics for its members, which provide care directly, rather than through insurance.[1]

In recent years, there have been dramatic changes in the structure of health care delivery systems throughout the country. Instead of being delivered by individual hospitals and other providers, health care today is being delivered through complex, multi-provider integrated delivery systems, often referred to as health care networks or

[1] Under New York State law, these clinics are "hospitals" that fall within the scope of article 28 of the New York Public Health Law. *See* N.Y. PUB. HEALTH LAW § 2801(1) (McKinney 1993).

alliances.[2] These integrated delivery systems may consist of several hospitals, as well as home care providers, physician networks, clinics, nursing homes and a full range of other health care providers that have allied themselves to compete more effectively in the managed care environment. These alliances also increasingly involve payers, such as health maintenance organizations ("HMOs"). Another recent phenomenon is that many employers are either contracting directly with provider networks or establishing their own clinics and networks, eliminating the role of the third-party payer and altering the traditional role of the community-based hospital.

Most states, and New York State in particular, have a long tradition of regulating health care delivery, cost and access. As two of the premier not-for-profit health care associations in the country, HANYS and AHA are vitally interested in the preservation of community-based health care delivery systems that assure comprehensive, readily-accessible, cost-effective and high-quality health care.[3] The decision of the Second Circuit Court of Appeals, however, will encourage the growth of hospitals and health care net-

[2] This is discussed in greater detail in Point I(B) below.

[3] HANYS is a not-for-profit, tax-exempt trade association that represents over 220 public and private not-for-profit acute care general hospitals across the State of New York, as well as nursing homes, home health agencies, and other entities. HANYS is the principal advocacy organization on behalf of New York's hospital industry and provides technical, administrative, legal and other services on behalf of its members.

Founded in 1898, the AHA is the primary national organization of hospitals in the United States. Its institutional members include approximately 70% of the nation's hospitals, and nearly 40,000 health care professionals hold individual memberships. The AHA's corporate mission is to lead, represent, and serve health care provider organizations that are accountable to the community and committed to health improvement. To fulfill this mission, the AHA regularly participates in the judicial and legislative arenas to address important issues concerning federal and state health care reform in general and hospital regulation in particular.

works that thrive, at the expense of the *amici's* members, from both an immunity to state regulation and an avoidance of the public responsibilities that HANYS's and AHA's members share. HANYS and AHA, therefore, consider the Court's decision here to be of paramount importance to the future of health care throughout the country.

SUMMARY OF ARGUMENT

On remand from this Court, *Chassin v. NYSA-ILA Med. & Clinical Servs. Fund*, 115 S. Ct. 1819 (1995), to reconsider its prior decision in this case, *NYSA-ILA Med. & Clinical Servs. Fund v. Axelrod*, 27 F.3d 823 (2d Cir. 1994), in light of *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 115 S. Ct. 1671 (1995) ("*Travelers*"), the Second Circuit held that ERISA bars a state from applying a general hospital gross receipts tax to hospitals operated by an ERISA plan on the ground that the tax "depletes the Fund's assets directly, and thus has an immediate impact on the operations of an ERISA plan." *NYSA-ILA Med. & Clinical Servs. Fund v. Axelrod*, 74 F.3d 28, 30 (2d Cir. 1996). The Second Circuit further held that *Travelers* has no effect upon its decision because *Travelers* dealt with an indirect economic impact, while *NYSA-ILA* deals with a direct economic impact.

The Second Circuit erred in holding that preemption under ERISA depended upon whether or not the state law's economic impact upon an ERISA plan was direct or indirect. The test it employed has no precedent in prior decisions of the Supreme Court, nor support in either congressional history or the language of ERISA. Instead, prior decisions of this Court have found no preemption where the law's impact was direct, and have repeatedly advised that preemption may be found even when a law's impact is indirect. The mere existence of an economic impact upon plans, whether direct or indirect, is insufficient for preemption. Rather, as stated in *Travelers*, the analysis must center upon the effect that the state law

has upon plan decisions, or plan administration, not simply whether it increases the costs of those decisions, directly or indirectly. The Second Circuit test would result in immunizing ERISA plan-owned health care facilities from any state regulation, a result Congress could not have intended.

The Second Circuit's test would also be virtually impossible to apply with any consistency or rationality, particularly because of changes in the health care delivery system that blur any distinction that once might have existed between direct and indirect effects. Finally, the state law at issue here does not relate to ERISA plans; it relates to hospitals. A plan's decision on how to provide health care coverage to its members may be protected from improper state interference, but once that decision is made and the plan decides to establish a hospital, that hospital must be subject to the same laws that apply to all hospitals. The operation of a hospital is not a plan function intended to be protected by ERISA from any state interference. A hospital is not an ERISA plan, nor is it a plan benefit; it is the manner by which the benefit is provided.

ARGUMENT

I. THE DIRECT/INDIRECT DICHOTOMY IS AN IMPROPER TEST FOR DETERMINING ERISA PREEMPTION

A. The Test Has No Precedent

This Court and lower courts have struggled since the inception of ERISA to define how far the broad preemptive scope of ERISA extends. *See Travelers*, 115 S. Ct. at 1675-78. This Court has emphasized that in any preemption question, ultimately, congressional intent is the touchstone. *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 516 (1992). Attempting to define when a state law will be preempted, this Court has advised that a state law will "relate to" an ERISA plan "if it has a connection

with or reference to" a plan. *Shaw v. Delta Air Lines*, 463 U.S. 85, 96-97 (1983). Under the "connection with" standard, this Court has cautioned that a state law may be preempted even if it is not specifically designed to affect ERISA plans. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990). Nevertheless, many laws of general application are not preempted where they have only a "tenuous, remote, or peripheral" connection with covered plans. *Shaw*, 463 U.S. at 100 n.21.

In *Travelers*, this Court recognized that prior attempts to construe the phrase "relate to" did not provide much help in drawing the preemption line, and that the phrases "relate to" and "connection with" cannot be interpreted too literally to define the measure of preemption. *Travelers*, 115 S. Ct. at 1676-77. Rather, the Court in *Travelers* stated that it must "look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* at 1677. This Court therefore conducted a comprehensive review of the purposes of the ERISA preemption provision and its legislative history, as well as congressional activity in the field of health care regulation, to determine the reach of ERISA preemption in connection with hospital rate regulation. *Id.* at 1677-82. Considering the surcharges at issue in *Travelers*, this Court distinguished laws with mere indirect economic impacts on plans from laws which mandate plan behavior. *Id.* at 1679.

What the Supreme Court has never said, and what Congress also did not say, is that the determinative test for ERISA preemption was to be merely whether the impact of the state law was direct or indirect. It would have been easy for Congress to have said so, and just as easy for this Court to have so pronounced. Congress, however, simply "did not write the statute that way," *Russello v. United States*, 464 U.S. 16, 23 (1983), and "[i]n a comprehensive regulatory scheme like ERISA, such omissions are

significant ones." *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825, 837 (1988). *See also BFP v. Resolution Trust Corp.*, 114 S. Ct. 1757, 1761 (1994). Instead, Congress used broad language, which this Court has held necessitates resort to traditional rules of preemption analysis to determine Congressional intent.

This Court has held that the preemption line is to be drawn based on the compulsory nature of the law or its effect upon plan administration, not on the directness of its impact. In *Mackey*, for instance, the Court found that ERISA did not preempt the direct application of a state garnishment law to benefits earned under an ERISA welfare plan. The Court explained that Congress simply never intended to block the application of run-of-the-mill state laws, such as garnishment statutes, to ERISA plans. If direct economic impact were the test, the result in *Mackey* should have been different.

The direct/indirect analysis employed by the Second Circuit must also be rejected because this Court has made clear that laws with indirect effects can also be preempted. In *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981), it was stated:

> it is of no moment that New Jersey intrudes indirectly, through a workers' compensation law, rather than directly, through a statute called 'pension regulation.' ERISA makes clear that even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern.

See also Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 139 (1990); *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 129-30 (1992). In *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 704 (1985), this Court held that a mandated benefit law related to plans even though it only bore indirectly on such plans. And in *Travelers*, the decision concluded with the observation that laws with "acute, albeit indirect" economic effects might be preempted if they force plans

to behave in a certain manner. *Travelers*, 115 S. Ct. at 1683. If, as these cases teach, laws which bear indirectly upon ERISA plans may relate to such plans, then the determinative factor in *Travelers* could not have been simply the indirectness of the economic impact. Likewise, the question of preemption in *NYSA-ILA* cannot turn simply on whether the law affects plans directly or indirectly.[4]

B. The Test Is Impractical

A direct/indirect distinction not only has no support in prior decisions of this Court, but it would also prove to be too impractical to justify its adoption. The difficulty in separating direct from indirect effects is evident from the fact that the test was misapplied by the Second Circuit in *NYSA-ILA*. The medical centers that are the subject of this action and upon which the health facilities assessment was imposed were incorporated as not-for-profit corporations under special acts of the New York State Legislature. (Joint Appendix at 98). These medical centers are legal entities separate from the self-insured plan that established them. The assessment was not imposed upon the ERISA fund, but upon a separate hospital. The impact upon the ERISA fund, therefore, was not a function of the law itself, but rather of the relationship voluntarily established between the fund and the hospital. There did exist, therefore, the very "middleman" between the tax and the Fund that the Second Circuit stated to be absent.

[4] In other contexts as well, this Court has refused to accept a direct/indirect distinction as having any legal significance in determining congressional intent. Thus, in *Grove City College v. Bell*, 465 U.S. 555, 563-65 (1984), the Court rejected the argument that the characterization of federal assistance as direct or indirect would determine the application of a federal statute prohibiting sex discrimination in any education program or activity receiving Federal financial assistance. Instead, the Court in *Grove City* conducted a comprehensive review of congressional history and intent to discern the intended reach of the statute, much as this Court did in *Travelers*.

The line between direct and indirect impacts is far harder to discern than the Second Circuit perceived. As the health care system becomes more complex and payers and providers integrate, or assume multiple functions, the direct/indirect distinction will become more blurred.[5] State legislatures have begun to respond to this phenomenon. The Minnesota legislature, for example, has created integrated service networks that organize hospitals, physicians and insurance plans. *See* John E. Kralewski, et al., *The development of integrated service networks in Minnesota*, HEALTH CARE MGMT. REV., Fall 1995, at 42-56. New York recently enacted the Health Care Reform Act of 1996, which will create a new category of managed care licensure known as Integrated Delivery Systems. 1996 N.Y. Laws ch. 639, § 112-b (codified at N.Y. PUB. HEALTH LAW § 4408-a).

As *NYSA-ILA* shows, ERISA plans, employers and insurance companies are setting up their own health care

[5] In 1994, the Hospital Trustees of New York State reported that 45% of acute care facilities surveyed nationwide had formed an integrated delivery system in the preceding twelve months, and that another 25% indicated that they would enter into some form of integrated care in the coming six months. HOSPITAL TRUSTEES OF NEW YORK STATE, AN INTRODUCTION TO HEALTH CARE NETWORKS (1994). In New York City, hospital system and network formation has been so great that another 1994 survey conducted by the Greater New York Hospital Association reported that 82% of respondents were already in at least one network or system, more than 1 in 3 reported being in two or more networks, and almost half were part of a system in which they had equity or ownership in a managed care organization. *Id.* at 6. While there are many reasons for the formation of networks, "the most pressing is the clear indication that the healthcare reform discussions will result in some financing system that will reward the efficiencies suggested by streamlining and integrating care through networks." *Id.* at i. Just two years later, virtually all hospitals in New York State are now integrated with other hospitals, providers or payers in health care networks. *See also* PATRICIA A. BUTLER & ELIZABETH MITCHELL, HEALTH CARE PROVIDER NETWORKS; REGULATORY ISSUES FOR STATE POLICY MATTERS (National Academy for State Health Policy, Feb. 1996).

delivery systems. Recently reported examples include an occupational health clinic being built by Delta Air Lines in cooperation with its health insurer, CIGNA Health Care Inc., to be staffed by Emory University doctors. Robert Kazel, *Onsite clinic expected to cut Delta comp tab*, BUS. INS., Jan. 29, 1996, at 6. Deere & Co. has set up its own clinics and opened them to other companies. Louise Kertesz, *Employers, insurers center attention on primary care*, MOD. HEALTHCARE, June 19, 1995, at 136 (describing the "rush" of companies to build their own facilities). Quad/Graphics Inc. is planning to build its second onsite medical facility in five years, this time jointly with a Milwaukee-based system of 1,500 doctors, four hospitals and various other medical facilities. Robert Kazel, *Lowering costs onsite*, BUS. INS., October 23, 1995, at 2, 104.[6] It is also common for hospitals and unions to be establishing their own health maintenance organizations, or for insurance companies, HMOs, hospitals and other providers to form partnerships, sharing capital investments and financial risks.[7]

The implications of the Second Circuit decision in light of the revolutionary changes in health care are profound. If the impact of the HFA in *NYSA-ILA* was direct upon the plan because the plan owned the medical center, there should be no reason that the same result would not be

[6] Employers are also setting up their own child care centers (*see, e.g.*, Bruce Shutan, *Higher learning for K through* 3, EMPLOYEE BENEFIT NEWS, Feb. 1996, at 9; *How one employer implemented on-site child care*, Employee Benefits Mgmt. Directions (CCH) No. 109, July 11, 1995, at 1, 4; Robert N. Kazel, *New York Life sets up backup care center*, BUS. INS. Nov. 13, 1995, at 58), and legal services plans (*see, e.g.*, Leigh P. Perkins, *Solo Wins Prepaid Contract, Creates Instant Firm*, LAW. WKLY. USA, May 22, 1995, at 7-9), two of the other benefits that ERISA plans may provide in kind.

[7] *See* James C. Robinson, *Health Care Purchasing and Market Changes in California*, HEALTH AFFAIRS, WINTER 1995, at 117-30 (describing how previously autonomous organizations are consolidating into complex networks).

reached if the plan was a 75%, 50% or just 25% owner —the tax would still fall directly on the plan. A hospital, indeed an entire integrated delivery system, could immunize itself from state taxes and other costly regulation merely by transferring a minority ownership or operational interest to an ERISA plan. Similarly, it would appear that the 9% assessment in *Travelers* would have been preempted if the HMOs had been established by ERISA plans, or if the plans were part owners of the HMO.

The entanglement between plans and providers can occur in numerous other ways. If a hospital has a contract to provide care to a plan's members, and the plan agrees to share in the hospital's costs, would the HFA on the hospital be preempted as having a direct impact on the plan?[8] If not, how is that substantively different from the facts in *NYSA-ILA*? And if it is not substantively different, then a very easy solution has been found for providers to avoid state regulation—simply affiliate with an ERISA plan. If the NYSA-ILA hospitals establish a wholly-owned nursing home as a subsidiary, would the HFA applied against this nursing home be considered a direct or indirect assessment on the NYSA-ILA Fund?

The health care delivery and payer systems that are developing could not have been envisioned by Congress when it enacted ERISA in 1974. At that time, HMOs were in their infancy, managed care was a concept for the future, and integrated delivery systems and alliances were nonexistent. Health care delivery systems have been revolutionized since 1974, and the distinctions between employers, payers and providers are rapidly disappearing.

[8] The Fund here seeks immunity from the taxes not just on revenues attributable to services provided to longshore workers, retirees and dependents employed by NYSA employers, or even ILA members employed by non-longshore employers, but also to services provided to members of another union, the Port Police and Guards Union, pursuant simply to a contract between the PPGU's ERISA-covered plan and the Fund.

If a direct/indirect test could have had viability in 1974, it cannot now.

C. The Proper Analysis

The proper inquiry is not whether a state law that causes an economic impact upon plans does so directly or indirectly, but whether the law mandates an employee benefit plan's structure or administration. If it does, it does not matter whether it does so directly or indirectly. It is now well-established that Congress's purpose in enacting ERISA's preemption provision was to ensure that the field of employee benefit plans would be exclusively a federal concern. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981). Specifically, Congress intended to eliminate the threat of conflicting and inconsistent state or local regulation of ERISA plans so that such plans could be structured and operated under a nationally uniform set of rules. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). *See also Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990) (ERISA's preemption provision "was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law"); *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990) (ERISA ensures that plan providers would not have "to design their programs in an environment of differing state regulations [thereby] complicat[ing] the administration of nationwide plans.")

This Court, therefore, has distinguished state laws that impair an ERISA plan's ability to maintain a uniform structure and/or administration from other types of state laws that merely brush against such plans. In *Alessi, supra*, this Court ruled that ERISA preempted a New Jersey law that prohibited pension plans from offsetting workers' compensation benefits because it interfered with a plan's right to determine its pension benefits. Similarly, in *Greater Washington Bd. of Trade, supra*, and *Shaw, supra*, the Court found the respective state laws at issue

related to ERISA plans because they required plans to provide benefits to certain classes of individuals. And, in *FMC Corp., supra*, the Court held that a Pennsylvania anti-subrogation law could not prevent ERISA plans from being structured to seek reimbursement of certain medical benefits it pays to participants who recover from a third party.

On the other hand, in recognizing that ERISA plans are not free to operate in a world immune from all state laws, the Court in *Mackey, supra*, upheld the application of Georgia's general garnishment statute to benefits earned under an ERISA welfare plan. There, the Court reasoned that Congress never intended to exempt ERISA plans from a range of garden variety state laws that function without any particular regard to ERISA plans.

In *Travelers*, this Court ruled that ERISA did not preempt the imposition of three separate surcharges on state-regulated hospital rates. Although the surcharges were "passed on at least in part" to ERISA plans that provide certain health care benefits (*Travelers*, 115 S. Ct. at 1678), the Court explained that the economic nature of the impact was a "far cry" from the conflicting state directives that Congress was concerned about when it enacted ERISA. *Id.* at 1679. The surcharges simply affected the cost and type of benefits that a plan voluntarily decides to undertake.

In *Travelers*, therefore, this Court was not driven to the result by reason of the indirectness of the impact, but rather because the indirect influence "does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself." *Id.* Similarly, the mandatory nature of a law, and not the directness of its impact, was the concern of the Court when it cautioned that:

> a state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of

> insurers, and that such a state law might indeed be pre-empted under § 514.

Id. at 1683. But where the statute merely affects the cost of doing business, it is not preempted, whether it does so directly or indirectly.

II. HOSPITALS OPERATED BY ERISA PLANS ARE SUBJECT TO THE SAME LAWS THAT APPLY TO ALL OTHER HOSPITALS

The law at issue here is not a law that relates to ERISA plans; it is a law that relates to hospitals. ERISA plans were never intended to lead a "charmed existence." *Rebaldo v. Cuomo*, 749 F.2d 133, 139 (2d Cir. 1984). There is a difference between what a plan does as a plan and what it does as a hospital, landlord, or day care center. A plan's decision to self-insure, insure commercially or establish its own hospital and provide direct health care may be protected from state regulation, but once that decision is made, the plan is not immunized from regulation of the choice it makes. That point was established in *Travelers*. Once a plan decides to own or operate its own hospital, that hospital must be subject to the same regulation as all other hospitals, whether it be a gross receipts tax or a quality of care standard. Where such laws are applied evenly to all hospitals, they are laws of general application whose connection with plans is too "tenuous, remote, or peripheral" to be preempted.

A. The Direct/Indirect Test Would Displace General Health Care Regulation

Travelers made clear that:

> nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern[.]

Travelers, 115 S. Ct. at 1680. The Court warned that "it is fair to conclude that mandates for rate differentials would not be pre-empted unless other regulation with indirect effects on plan costs would be superseded as well." *Id.* at 1679. Thus, quality control and workplace regulations would fall because they would indirectly impact plan decisions. *Id.* Similarly, this Court in *Travelers* stressed that any other result would bar any state regulation of hospital costs, as well as the DRG system itself and any other interference in the hospital services market. *Id.* at 1681.

While *Travelers* made clear that ERISA's preemption provision should not be read too broadly so as to displace general health care regulation, it is just this displacement that will occur if the Second Circuit decision is upheld. Respondents' position, as reflected in the Second Circuit decision, creates an anomalous situation that could not represent Congress's intent. Unless Respondents contend that they are exempt from New York's laws of general application prohibiting the unlicensed corporate practice of medicine (*see* N.Y. EDUC. LAW § 6522 (McKinney 1985); N.Y. PUB. HEALTH LAW § 2801-a (McKinney 1993 & Supp. 1996)), they have accepted the right of the state to determine who or what entities may practice medicine in this state by obtaining the state's licensure under article 28 of New York's Public Health Law. These licensure laws obviously impact the medical centers directly because these laws control the fundamental question of whether or not the medical centers may be established. *See* N.Y. PUB. HEALTH LAW § 2801-a (McKinney 1993 & Supp. 1996). But if the Fund's medical centers are immune from a tax on hospitals, they should be equally immune from a state law requiring that those hospitals be licensed before they can dispense medical care. Certainly, a state law that controls whether the medical center can even exist relates more directly to the sponsoring plan than just a tax imposed on payments to the hospital for its services.

As with section 2801-a of the Public Health Law, the HFA applies to all hospitals regardless of whether the hospital is owned or operated by an ERISA plan.

These are both laws of general applicafion that operate in a traditional field of state regulation—health care. The HFA does not mandate plan structure or plan administration. It does not affect national uniformity. Like the surcharges in *Travelers* and so many other laws that relate to hospitals, the HFA merely increases the cost of doing business as a hospital. But in this regard, there is no difference between a tax imposed on gross revenues or laws requiring personnel standards, quality assurance, discharge planning, waste disposal or properly maintained equipment. They all increase the costs of doing business and are all imposed directly on hospitals.

Health care regulation is oftentimes undesirable for the provider. Regulation makes operations more difficult and more costly. But it is a traditional police power exercise to protect and promote the health of the populace. *See* N.Y. CONST. art. XVII, § 3. This Court determined in *Travelers* that Congress never intended ERISA to preempt that traditional state authority. If the HFA is preempted because it directly reduces the assets of the plan otherwise available to provide health care benefits, *NYSA-ILA Med. & Clinical Servs. Fund v. Axelrod*, 27 F.3d at 826, so will myriad other state laws be preempted that impose other or more expensive burdens upon the Fund's hospitals. Congress could not have intended that individual hospitals or integrated delivery systems be exempt from such regulation simply because they have a close relationship to an ERISA plan. The fact that the Fund here has voluntarily decided to operate a hospital does not change the ERISA-neutral character of the law. Instead, it is the plan which has changed its character from a plan to a health care provider.

B. Operating a Hospital Is Not a Plan Function or Benefit

Operating a hospital is different from administering a plan, which is what ERISA's preemption provision was intended to protect. In *Fort Halifax Packing Co. v. Coyne*,

482 U.S. 1, 9 (1987), the Court explained that ERISA's preemption provision was prompted by a recognition that a plan is the product of various complex administrative practices, including determining the eligibility of claimants, calculating benefit levels, making disbursements and maintaining appropriate records. By eliminating the threat of a patchwork scheme of state regulation over those administrative practices, the preemption provision was designed to ensure "that the administrative practices of a benefit plan will be governed by only a single set of regulations." *Id.* at 11.

Not all activities performed by a plan constitute administrative practices protected by ERISA. ERISA plans may be tenants, parties to contracts and tortfeasors. Yet, "run-of-the-mill" state law causes of action such as for unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan are not preempted. *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 824, 833 (1988). Even though these every-day activities may, ultimately, support a plan's operations, laws regulating them are simply "too tenuous, remote and peripheral" to relate to a plan's ERISA functions. *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 130 n.1 (1992).

In operating two hospitals, an area of traditional state regulation, the Fund performs a variety of activities ranging from credentialing professionals and maintaining equipment to disposing medical waste. Neither those activities nor the payment of taxes concern the administrative practices that this Court has identified as ERISA plan functions.

This distinction between a plan's ERISA and non-ERISA activities is also consistent with the recognition that, for purposes of the statute, a single entity may wear more than one hat. In *Varity Corp. v. Howe*, 116 S. Ct. 1065 (1996), this Court found that in making misrepre-

sentations about plan benefits, an employer was acting in its ERISA role as a plan fiduciary as opposed to its non-ERISA role as an employer, and was thus liable under ERISA for the harm the misrepresentations caused. This should be contrasted with the action of a plan in hiring and firing employees. The plan would be acting in its non-ERISA role as an employer, and not in its ERISA role as an employee benefits plan. The employment relationship would be subject to all state employment laws that do not interfere with plan structure or administration.

Another way of distinguishing between plan and non-plan activities is to differentiate between plans and benefits. ERISA preempts laws relating to plans, and not laws relating to benefits. Where, as here, benefits are provided in kind, the state is not precluded from regulating those benefits.

> The words "benefit" and "plan" are used separately throughout ERISA, and nowhere in the statute are they treated as the equivalent of one another. Given the basic difference between a "benefit" and "plan," Congress' choice of language is significant in its preemption of only the latter.

Fort Halifax, 482 U.S. at 8.

Based on that difference, this Court in *Fort Halifax* upheld Maine's severance benefit law because the law's one-time payment obligation failed to constitute an ongoing administrative scheme necessary to have a plan. The Court explained that since the Maine law did not require an ERISA plan, the law did not create an impediment to ERISA's uniformity objective.[9] In *Travelers* this

[9] This result would not have been any different if an employer decided to comply with Maine's severance obligations through an ERISA plan. While an employer would have been free to structure its ERISA plan to satisfy its legal obligations, the state law did not mandate such a structure. *See also Shaw v. Delta Air Lines*, 463 U.S. at 108 ("while the State may not require an employer to alter its ERISA plan, it may force the employer to choose between providing disability benefits in a separately administered plan and including the state-mandated benefits in its ERISA plan.").

Court held that the surcharges were not preempted even though they increased the cost of providing health benefits because the higher costs did not preclude uniform administrative practices or the provision of a uniform interstate benefit package. *Travelers*, 115 S. Ct. at 1679. This is exactly the case with the HFA—it increases the cost of providing the benefit, but has no impact on the plan itself.[10]

Insofar as the HFA applies to the Fund, it does so in the Fund's role as the operator of a hospital, and not as an employee benefits plan. The fact that the Fund has elected to provide its benefits in the form of hospital services instead of insurance does not change this result. Rather, it only means that the Fund has decided to provide the benefit of health care coverage through direct provision of care, rather than through insurance. There are a multitude of costs and other factors, such as liability for malpractice, that enter into the decision of an ERISA plan whether to provide care directly or through insurance. The HFA is just one of those costs that affect the decision,

[10] The difference between plans and benefits also finds support in ERISA's legislative history. During the floor debates, Senator Javits, a sponsor of ERISA, explained that while a state may not regulate the "form and content" of an ERISA legal services plan, a state may impose ethical rules and guidelines, and institute disciplinary procedures with respect to the actual attorney services rendered under such a plan. 3 LEGISLATIVE HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, at 4789 (1976). In addition, following his oft-cited remark that ERISA's preemption provision is the statute's "crowning achievement," Representative Dent, another sponsor of ERISA, explained that the provision was modeled after the preemption provision in the Health Maintenance Organization Act of 1973, (the "HMO Act"), Pub. L. No. 93-222, 87 Stat. 914 § 2 sec. 1311 (codified at 42 U.S.C. § 300e-10 (1994)). 3 LEGISLATIVE HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, at 4670 (1976). That Act, however, regulates only the formation and operation of HMOs, and not the medical services and/or benefits they offer.

no different from how the surcharges in *Travelers* affected, but did not determine, the coverage decision.

CONCLUSION

The judgment of the United States Court of Appeals for the Second Circuit should be reversed.

Respectfully submitted,

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November 29, 1996